**Supplement - Postpartum Symptom Inventory**

**In the last 7 days, how often have you been bothered by the following**:

(Please mark **one** answer for each symptom):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Symptom | Never | Rarely | Sometimes | Often | Always |
| Tiredness or Fatigue |  |  |  |  |  |
| Insomnia |  |  |  |  |  |
| Headache |  |  |  |  |  |
| Nausea |  |  |  |  |  |
| Heartburn/Indigestion |  |  |  |  |  |
| Urinary Incontinence (inability to control urine) |  |  |  |  |  |
| Increased urinary frequency |  |  |  |  |  |
| Fecal incontinence (inability to control bowel) |  |  |  |  |  |
| Constipation |  |  |  |  |  |
| Hemorrhoids |  |  |  |  |  |
| Backache/ Hip pain |  |  |  |  |  |
| Abdominal/ Pelvic pain |  |  |  |  |  |
| Breast pain |  |  |  |  |  |
| Vaginal pain |  |  |  |  |  |
| Change in Sexual Drive |  |  |  |  |  |
| Pain during sexual intercourse |  |  |  |  |  |
| Painful veins (varicose veins) |  |  |  |  |  |
| Abnormal or persistent vaginal bleeding |  |  |  |  |  |
| Vaginal Discharge |  |  |  |  |  |
| Hot flashes |  |  |  |  |  |